Dr. Eliseo Pérez-Stable – Director of the National Institute of Minority Health and Health Disparities at the National Institutes of Health

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Mark Masselli: This is Conversations on Health Care. I am Mark Masselli.

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: Well Margaret, another year, another celebration of the legacy of Dr. Martin Luther King Jr. whose quest for equality extended to one of the most basic civil rights, that of equal access to decent health care for all citizens of this country.

Margaret Flinter: And health disparity is still very much a reality in this country and around the world, though we are starting to see some progress.

Mark Masselli: Millions of Americans have gained access to health coverage under the Affordable Care Act - it's not a perfect solution, but we are seeing a significant shift towards inclusion in the American health care system for citizens.

Margaret Flinter: The Executive Director of the Tennessee Justice Center predicts that the act will close the racial gap in health coverage and that's a prerequisite for eliminating disparities in health care and health status. And we're starting to see that manifest here, Mark.

Mark Masselli: And in just a few years, we have seen America's uninsured rate go from as high as 18%, or around 50 million Americans, down to under 10% - a significant progress has been made, but there is much more work to do in advance of the cause of health equality in this country.

Margaret Flinter: And our guest today is somebody who has devoted his professional, medical and research career to eliminating disparities in health, Dr. Eliseo Pérez-Stable is the Director of the National Institute of Minority Health and Health Disparities at the National Institutes of Health where he oversees the research being conducted on minority health issues and improving the health of minorities in this country.

Mark Masselli: Lori Robertson, stops by as well, the Managing Editor of FactCheck.org, is always on the hunt for misstatements spoken about health policy in the public domain. You can hear all of our shows by going to www.chcradio.com.

Margaret Flinter: And as always, if you have comments, please e-mail us at chcradio@chc1.com, or find us on Facebook or Twitter because we love to hear from you. Now we get to our interview with Dr. Eliseo Pérez-Stable in just a moment.

Mark Masselli: But first, here is our producer Marianne O'Hare with this week's Headline News.

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Marianne O'Hare: I am Marianne O'Hare with these Health Care Headlines. Meaningful use won't survive the year of 2016 according to Andy Slavitt, Acting Administrator for the Centers of Medicare and Medicaid Services. Practices and hospitals have struggled to keep pace with meaningful use requirements which are tied to performance and use of electronic medical records paid for with government grants. Many health entities warned they were giving up on meaningful use 3 due to inherent challenges even meeting meaningful use 2 requirements. Slavitt promised there would be something better to replace meaningful use, though it's unclear yet what that will be.

On the heels on the president's call for a Moonshot for Cancer during his State of the Union address the National Institutes of Health is announcing plans to launch a data sharing commons for researchers around the nation and the world to more easily share not just their academic papers, but their data as well. And the Department of Health and Human Services is seeking input from researchers on the kinds of Cloud services that would facilitate better sharing of health research data.

The Lead Poisoning Crisis in Flint, Michigan continues to unfold, Michigan's governor asking for federal disaster aid, the Red Cross has been frantically trying to keep up with demand for drinking water after it came to light the city's water supply had dangerously high levels of lead. Not only have hundreds of thousands of residents been exposed to lead in their drinking water for over a year, but switching to clean water now after months of lead exposure may not be enough to mitigate the impact on children's growing brains. The World Health Organization links lead exposure to permanent developmental deficits in children who are exposed over a period of time.

And opioid addiction has gained necessary traction as a deadly and costly public health crisis, with deaths from overdose on the rise and few treatment options available. The FDA has just approved a long-term implant that delivers treatment to patients for six months. The medicine is delivered to opioid receptors in the brain, diminishing the cravings without delivering a high. Officials see this six-month long implantable solution a viable one for those who are on daily treatments and are doing well at managing their addiction.

I am Marianne O'Hare with these Health Care Headlines.

(Music)

Dr. Eliseo Pérez-Stable – Director of the National Institute of Minority Health and Health Disparities at the National Institutes of Health

Mark Masselli: We are speaking today with Eliseo Pérez-Stable, Director of the National Institute of Minority Health and Health Disparities at the National Institutes of Health. Prior to joining the NIH, Dr. Pérez-Stable spent 37 years at UC, San Francisco, serving as Chief of the Division of General Internal Medicine, and Director of both the Center for Aging in Diverse Communities and the Medical Effectiveness Research Center for Diverse Populations. Dr. Pérez-Stable was elected to the National Academy of Medicine. He earned his M.D. at the University of Miami School of Medicine, and completed his residency at UCSF School of Medicine. Dr. Pérez-Stable, welcome to Conversations on Health Care.

Dr. Eliseo Pérez-Stable: Thank you for having me.

Mark Masselli: Yeah, and it's January and as we said Martin Luther King Day and who once famously said that of all of the forms of injustice, injustice in health care is the most shocking and inhumane and we are a nation in the midst of transformation of their health care systems, but you have spent decades researching the link between ethnic minority status, income and health disparities. Could you help our listeners understand how health disparities impact specific populations and how entrenched these disparities really are today?

Dr. Eliseo Pérez-Stable: Yes, to understand health and health care disparities, one has to conceive of the problem as multidimensional. To begin with is the social determinants of the individual - how poor they are, what kind of education they had, where they lived. The individual's behavior also influences health disparities. Then the environment and the family, the place where one lives, influences the individual tremendously, and finally, the importance of biology and how differences in biological mechanisms and how things work in different individuals has become much more clear over the last 25 years. All of these things interact with the health system. The big change, of course, in the last six years has been the Affordable Care Act, which has increased excess. That's just one step towards improving or reducing health disparities.

Margaret Flinter: Well, you have analyzed these issues, both as a researcher but also a practicing internist and from a pretty early juncture in your career, it's clear that you understood that health disparities are often promulgated by cultural barriers. And I understand you are Cuban-American immigrant yourself; maybe you could talk with us about the kinds of barriers that you have identified as most prevalent across the multitude of minority populations that you have studied.

Dr. Eliseo Pérez-Stable: Yes. We have to remember in this era of technology that medicine and health are really about human interactions, and it is the clinician with the patient that is at the fundamental base of health care. Patients come from a very broad spectrum. Clinicians tend to come from a much more narrow spectrum. Wealthy people don't usually become physicians nor do very

poor people have the opportunity to do so. One area of research that I embarked on was language factors. If the patient and the doctor don't speak the same language, communication is impaired. Another more universal one is literacy and use of jargon. So clinicians will have the tendency to fall back on the medical terminology that they learned medicine in and use words that patients, sometimes even well-educated patients, do not understand. Going into even more sophisticated communication issues is the area of numeracy where we are using proportions and risks and estimate of events happening that for the common individual is not very meaningful to say high risk, low risk or to give it a quantitative amount - a lot of people don't really grasp those concepts.

And finally, the whole issue of culture. There are expectations in culture that vary and acknowledging that or understanding that at least gives one insight. For example, in some cultures, the distance between people has to be maintained. In other cultures, it is appropriate and expected that one touch as the physician has a role in the culture that is of importance.

Mark Masselli: First of all, the larger context is that you have done a lot of research on a lot of things – 230 peer-reviewed articles analyzed everything from improving health of the minority and underserved populations, to improving cross-cultural communication skills among health care professionals, and how do we go about improving the ability of our primary care providers to have dialogue that is relevant with the population? What has your research shown?

Dr. Eliseo Pérez-Stable: Well, it varies according to the issues Too many times, we have physicians or clinicians, nurses included, who just speak a little bit of a language and try to "get by", and this is just – we are beyond that at this point. We should have professional interpreters in all of those interactions and this is I think we now have empirical evidence to support that care is compromised, the quality is limited. The clinicians who speak the language fluently should be evaluated as such so that we know that they are able to do this. On the other hand, too many times I have seen particularly among younger physicians get quickly into complex terminology and many, many patients are left behind. So being simple is important, and then step it up **[0:10:27]** they are more informed, they are more interested in getting more information and then provide that information - all of this is teachable. And then a final point relates to the shared decision making. So frequently a clinician will present to a patient a situation of here is in favor of doing A and here is what is not in favor of – you want treatment A or treatment B, here is the evidence, what are your preferences? You know, there a lot of times patients will come back and say, "Well, you are the doctor, you are supposed to tell me what to do." And so the balance between that, so still as a clinician be able to give a recommendation.

So I think this is an area I think that we don't do enough shared decision making for many situations, but when we do do it, I think there is still the element that we

need to say this is my opinion and I think sometimes doctors are hesitant to do that.

Mark Masselli: You were focused for a long time on certain issues specific to the Vietnamese and Latino populations in San Francisco, and realize that to meaningfully impact the health of these populations, that communication had to move really to the level of effective marketing. So tell us what did you learn from the culturally targeted campaigns around public health issues and problems.

Dr. Eliseo Pérez-Stable: So early on in my research career, we were funded by the National Institutes of Health, National Cancer Institute, for developing smoking cessation interventions for Latinos. I worked with social scientists and in the process, we discovered a number of things related to smoking behavior. Probably I think the most important was this notion of collective values, for the Latino Community. At the time, this is mid to late 1980s, all of the smoking cessation literature focused on behavior change for the individual. B We found that for the Latino population, they actually had a heightened concern about the collective values. So quitting for your children's sake, for your family's sake, and worrying about having bad breath, and not looking good, and which fit with a Latino cultural script that had been described by social psychologists called Simpatia, of wanting to **[please 0:12:51.4**]. My colleagues worked on the Vietnamese Community, used what we had discovered in Latino and applied it to the Vietnamese Community, and found very similar patterns in that community with, I think they also used the terminology of health is gold, in Vietnam, health being like gold, and it became the marker of their whole program, which continues to this day. And similar kind of principals were applied to things like getting cancer screening tests, but also needing to have access, where we now begin to interact with the healthcare system and being able to have to pay for it or have a place to go or have insurance to cover it.

So I think the messaging may need to be adapted or tailored to the population, and some level of tailoring has become now a standard approach.

Mark Masselli: We are speaking today with Dr. Eliseo Pérez-Stable who is the Director of the National Institute of Minority Health and Health Disparities at the National Institutes of Health, where his focus is on supporting research to improve minority health, as well as eliminating health disparities. Prior to joining the NIH, Dr. Pérez-Stable spent 37 years at UC San Francisco, as Chief of the division of General Internal Medicine and Director of both the Center for Aging in Diverse Communities, and the Medical Effectiveness Research Center for Diverse Populations. Dr. Pérez-Stable, you focus much of your research on how to improve care and eliminate health disparities, not only in the United States, but in many Latin-American countries. You are talking earlier about where you live is a good indicator of how your health might be **[0:14:40]** is there an analogous health equity index measure in Latin America in the context of how well they are,

and how does disparity play out in those regions and how are you able to make an impact in places like Argentina.

Dr. Eliseo Pérez-Stable: Yes I would say that as the global health becomes better across the entire spectrum, importance of place is heightened. All of Latin America is what we would call middle income. A couple of them are emerging - Brazil and Argentina in particular – Chile as well, emerging economies that are actually upper middle income. So once you reach that level then the global health problems go beyond childhood diseases of immunization or infant diarrhea or respiratory infections. Now these may still be problems, but they are much better managed, and in fact you look at Latin America and what are the leading causes of death. Well they have heart attacks, cancer and stroke – same as the United States.

So in Argentina there are tremendous regional variations. Buenos Aires is a grand capital with a large population, with the kind of problems that we would expect in Washington D.C. We did work in the very northwest corner of Argentina in a province called Jujuy, which is about 70% indigenous, a generally poor area, and we worked with adolescent youths, in a tobacco project, and discovered a couple of things.

Well first the patterns of transitions from non-smoker to smoker among these youths are not that dissimilar from what they are in the populations that have been studied in the United States. The rates were as high or higher with the typical more boys than girls smoking, and some of the issues such as depression and risk-taking behavior or attitudes playing a role – very little influence of parents and smoking, and much more important influence of peers, where you perceive your peers to be.

We did **[not 0:16:42**] use the model of health disparities and diversity that we have learned in the US, by asking about race ethnicity and found that youth were able to say, well I am indigenous, I am of Indian background, of native background. Or I am mixed, or I am white European. And the traditional pattern has been that the indigenous Americans have been the ones who have been discriminated against and held down historically. So I think this was a tremendously useful project to carry out and learn about. Because the diversity in Latin America, as a mixed population of three different continental origins, is really quite remarkable, and it represents a unique group to study and learn from.

Margaret Flinter: Well Dr. Pérez-Stable, you have won many accolades for many things in your career, but certainly you have been noted as an extraordinary teacher, and won the highest awards for medical teaching at the University of San Francisco School of Medicine. You're obviously passionate about inspiring the next generation of people who will provide healthcare, which is something we certainly share, and I wonder if you would comment on how modern health professions' training is being transformed to address these issues of disparities

and to develop the competencies needed to provide culturally competent care and how are you advancing that work and those ideas at the National Institute for Minority Health and Health Disparities.

Dr. Eliseo Pérez-Stable: Because NIMHD is focused on advancing research issues, this is not at the top of our agenda. We are promoting a diverse scientific workforce. There is a large investment made by NIH, led by Dr. Collins, called the Bill Program to enhance the pipeline. I am concerned that in 20 years the population of the United States will be - almost half will be non-white, and that the professional workforce is lagging way behind. On the physician front, only about 10% or 12% of entering medical students in 2015, self-identified as not being white. We cannot be so different than the population – not proportional to the population, I think that may be setting the bar too high, but we need to move it in the right direction. On the scientific workforce we face similar challenges, and this is from basic science, biology, research in the laboratory, to population science and behavioral and clinical science. So I think these are front and center for the NIH. I will note that the NIH did recruit and establish an office, a Chief Officer of Diversity, and recruited Hannah Valantine from Stanford to assume that role.

So she has been in her job now for little over a year and we have worked together on a couple of projects, and I look forward to continuing to work with her on these critically important issues.

Mark Masselli: We have been speaking today with Dr. Eliseo Pérez-Stable,. Director of the National Institute from Minority Health and Health Disparities at the National Institutes of Health. You can learn more about their work by going to nimhdnih.gov.

Dr. Pérez-Stable, thank you so much for joining us on Conversations on Healthcare.

Dr. Eliseo Pérez-Stable: Thank you very much.

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Mark Masselli: At Conversations on Health Care, we want our audience to be truly in the know when it comes to the facts about health care reform and policy. Lori Robertson is an award-winning journalist and managing editor of FactCheck.org, a nonpartisan, nonprofit consumer advocate for voters that aim to reduce the level of deception in US politics. Lori, what have you got for us this week?

Lori Robertson: In President Obama's final State of the Union address, he repeated his now years' long claim of crediting the Affordable Care Act for a slowdown in National Healthcare spending. But economists have linked the

slower spending growth mainly to the economy. In fact the growth rate jumped in 2014 when the law's coverage provisions were implemented. Obama said that under the ACA "nearly 18 million people have gained coverage so far, and in the process healthcare inflation has slowed. Health care spending has grown at historically low rates in recent years, but the slowdown started in 2009, a year before the ACA was signed into law. From 2009 to 2012, total national health care expenditures, rose at rates around 4% per year and they dipped as low as 2.9% in 2013. For 2014 a year in which the major coverage provisions of the law went into effect, health care spending growth jumped up to 5.3%. Experts have said the recent lower rates of growth have been largely a reflection of the sluggish economy. That comes from the non-profit Kaiser Family Foundation and experts with the Centers for Medicare and Medicaid Services who compiled the annual health care spending statistics. CMS's expert said in 2014 that the ACA had had a minimal impact. They estimated an average growth of 6% per year for about a decade starting in 2015 largely as a result of the continued implementation of the ACA coverage expansion and the aging of the population. That's my fact check for this week. I'm Lori Robertson, Managing Editor of FactCheck.org.

Margaret Flinter: FactCheck.org is committed to factual accuracy from the country's major political players and is a project of the Annenberg Public Policy Center at the University of Pennsylvania. If you have a fact that you would like checked, email us at www.chcradio.com, we will have FactCheck.org's Lori Robertson check it out for you here on Conversations on Health Care.

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Margaret Flinter: Each week Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. When Chef Karl Guggenmos grew up as a kid in postwar Germany, he lived on a diet of organic and locally grown foods. Now he is the Dean of the Culinary Arts Program at Johnson & Wales University in Rhode Island, and he realized that he has a responsibility to teach the next generation of chefs how vital natural and simple ingredients are, not just to creating good food, but to the health of the population as well. He teamed up with a Professor of Medicine at Tulane University Medical School in New Orleans, and together they created what they believe is the first course in Culinary Medicine in the United States, teaching chefs, and fourth year medical students, how to understand the synergy between healthy eating, good food, and good health.

Chef Karl Guggenmos: Our students are actually going to Tulane Medical School for an internship, and they work side by side with medical students and physicians, using an evidence-based approach to this whole idea of culinary medicine rather than anecdotal.

Margaret Flinter: So in addition to learning knife skills, sauté and poaching techniques, fourth year medical students are given a lesson in food pairings, learning which foods are most poised to foster good health, and to combat obesity in their future patients' lives.

Chef Karl Guggenmos: They identify ingredients as to their relationship to health, they then start basic introduction to cooking - from knife skills, to basically how to sauté, how to poach, how to roast and then they have to do research, and our students are there helping and being part of this whole program.

Margaret Flinter: A dean of a reputable culinary program teaming up with a medical school to train future doctors armed with the skills and information to assist their patients in healthier eating, fostering the development of health conscious chefs who are trained to feed the next generation well with foods that can prevent obesity, now that's a bright idea.

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Margaret Flinter: This is Conversations on Health Care. I'm Margaret Flinter.

Mark Masselli: And I'm Mark Masselli - peace and health.

Conversations on Health Care, broadcast from the campus of WESU at Wesleyan University, streaming live at www.wesufm.org and brought to you by the Community Health Center.